



## INSTRUCTIONS FOR COMPLETING THE IOWA MEDICAID HCBS WAIVER PROVIDER APPLICATION FORM

### I. GENERAL SECTION

- 1 **National Provider Identifier.** Complete this section **only** if you are a current Iowa Medicaid Provider. Enter the National Provider Identifier (NPI) for the provider. If you do not have an NPI, enter your ten-digit Iowa Medicaid Provider number (starting with "X00....").
- 2-7 Enter the location information for the provider.
- 8-9 **County Name and Number.** Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).
- 10 **Telephone Number.** Enter area code and phone number.
- 11 **Cellular Telephone Number.** Enter area code and phone number, if available.
- 12 **Fax.** Enter area code and fax number, if available.
- 13 **E-mail Address.** Enter e-mail address, if available. By providing us with your e-mail address, you agree that we may communicate with you by electronic mail.
- 14 **Desired Effective Date for Enrollment.** This date cannot be retroactive before the first of the month in which the application is approved. Providers cannot bill or be paid for service provided prior to DHS agreement to the service.
- 15 **HCBS Waiver.** Indicate the HCBS waiver program(s) for which application is being made. You may apply for more than one waiver type. Waiver types marked in this question should be the same as the ones circled in question 17 (for individuals) or question 25 (for agencies and businesses).

### II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

If you are applying on behalf of an agency, proceed to section III.

If you are an individual applying for services other than Consumer-Directed Attendant Care, proceed to Section III. **(This is not common!)**

- 16 **Social Security Number.** Enter your social security number here.
- 17 Indicate that you are applying for Consumer-Directed Attendant Care by checking the service and standard boxes.
- Individuals who apply to provide Consumer-Directed Attendant Care are required to submit proof of age and must send in a copy of either a birth certificate **OR** a driver's license. The date of birth must be clearly visible or it will not be accepted.
  - All of the forms must be completed. Individuals must fill out the W-9 form. All taxes on income earned from providing CDAC services are the responsibility of the individual providing the service.

**Note: The CDAC provider cannot bill or be paid for service provided prior to Department of Human Service written approval of this service. That is indicated by the case manager or DHS service worker attaching the *HCBS Consumer-Directed Attendant Care Agreement, form 470-3372*, to the service plan in the AIDS/HIV, Brain Injury, Elderly, Ill and Handicapped, Mental Retardation, and Physical Disability waivers. Any payments made prior to the case manager or DHS service worker written approval of this service are fraud, and referrals for recovery and prosecution of this federal offense will be made.**

- 18 **Signature.** Original signature required. Applications not properly signed will be returned.
- 19 **Date.** Enter date application is signed.

### III. AGENCIES AND BUSINESSES APPLYING FOR WAIVER SERVICES

- 16 **Tax ID Number.** Enter your IRS Tax ID number.
- 17 **Contact Person.** Enter the name of the person who should be contacted for questions in regards to the application.
- 18-22 Self-explanatory.
- 23 **Claims in Process Information.** Paid and denied claims will automatically be reported to you. You have three choices regarding suspended claims, i.e., claims currently in process pending resolution of one or more issues. Those choices are:
- Y = Print suspended claims only once. You will be notified only once that we have received your claim and that it is in process. You will not be notified about the claim again until it either pays or denies.
- A = Print all suspended claims until paid or denied. You will be notified every week about all claims that are in process.
- N = Do not print suspended claims. You will receive no notice concerning claims in process until they either pay or deny.
- 24 **Remittance Sequence.** Choose which sequence your claims will be reported to you. The choices are:
- By Member Name.* Claims will be reported in alphabetic order by member's last name.
- By Member ID.* Claims will be reported in numeric order by member's Medicaid ID number.
- 25 Indicate which services under which waivers you are applying for, and which standards you meet. Include with the application the documentation that the specific requirement is met.
- 26 **Signature.** Original signature required. Applications not properly signed will be returned.
- 27 **Date.** Enter date application is signed. Applications that are not dated will be returned.

# Medicaid HCBS Waiver Provider Application

When completed send to:

Iowa Medicaid Enterprise  
Provider Services  
P.O. Box 36450  
Des Moines, IA 50315

**Make sure you have read  
the instructions before completing this form!**

For questions, contact:

Provider Services  
**Tel. (800) 338-7909 or  
(515) 256-4609 (local)**

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) should complete sections I and II.  
Agencies and businesses applying to provide waiver services should complete sections I and III.

## I. GENERAL SECTION

1. National Provider Identifier (NPI) or Medicaid Number (if you are not currently a Medicaid provider, leave blank)																					
2. Provider Name																					
3. Mailing Address																					
4. Street Address (if different from the mailing address)																					
5. City															6. State						
7. Zip Code (please enter 9-digit zip code, if known)																					
8. County Name																9. County Number					
10. Telephone Number (daytime)										(				)							
11. Cellular Telephone Number (optional)										(				)							
12. Fax Number (if available)										(				)							
13. E-mail Address (please, print)																					
14. Desired Effective Date for Enrollment (MM/DD/YYYY) (THIS DATE WILL NOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS APPROVED)												/			/						
15. Indicate the HCBS waiver program(s) for which application is being made																					
<table border="0"> <tr> <td> <input type="checkbox"/> Ill &amp; Handicapped (IH)  <input type="checkbox"/> AIDS/HIV (AH)  <input type="checkbox"/> Elderly (E)  <input type="checkbox"/> Children's Mental Health (CMH) </td> <td> <input type="checkbox"/> Intellectual Disability (ID)  <input type="checkbox"/> Brain Injury (BI)*  <input type="checkbox"/> Physical Disability (PD) </td> </tr> </table>																				<input type="checkbox"/> Ill & Handicapped (IH) <input type="checkbox"/> AIDS/HIV (AH) <input type="checkbox"/> Elderly (E) <input type="checkbox"/> Children's Mental Health (CMH)	<input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Brain Injury (BI)* <input type="checkbox"/> Physical Disability (PD)
<input type="checkbox"/> Ill & Handicapped (IH) <input type="checkbox"/> AIDS/HIV (AH) <input type="checkbox"/> Elderly (E) <input type="checkbox"/> Children's Mental Health (CMH)	<input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Brain Injury (BI)* <input type="checkbox"/> Physical Disability (PD)																				
<p>* – Those wishing to provide services under the Brain Injury waiver need to submit documentation indicating training or experience with persons with brain injury. Training classes are available through DHS. A list of available times and locations is available online at:  <a href="http://www.dhs.state.ia.us/dhs2005/dhs_homepage/medical_assistance/medical_insurance/help_ownhome.html">http://www.dhs.state.ia.us/dhs2005/dhs_homepage/medical_assistance/medical_insurance/help_ownhome.html</a>.</p> <p>Agencies applying for Home and Vehicle Modifications (HVM), Specialized Medical Equipment (SME), Personal Emergency Response (PERS), and Transportation under the BI waiver are exempt from the training requirement.</p>																					

**If you are an individual applicant applying for Consumer-Directed Attendant Care (CDAC), please, proceed to section II. Otherwise, proceed to section III.**

## II. INDIVIDUAL APPLICANTS APPLYING FOR CONSUMER-DIRECTED ATTENDANT CARE

<b>16. Social Security Number</b>				—		—			
<b>17.</b> Indicate that you are applying for Consumer-Directed Attendant Care (CDAC) by checking boxes below and circling the waiver(s) for which you are applying.									
<b>Service and Requirements</b>	<b>Circle the waiver(s) for which you are applying</b>								
<input type="checkbox"/> <b>04 – Consumer Directed Attendant Care (CDAC)</b>									
<input type="checkbox"/> <b>21 – Individual Applicant</b> (Attach a photocopy of birth certificate <u>OR</u> driver's license. The document must show name and date of birth.)						→ IH AH E ID BI* PD			
<p>❖ Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. There is no charge to you for this training. This training can be waived if you have experience or training in working with persons with brain injuries. If you have the experience or training in this area, please submit written documentation with this application.</p> <p>Upon receipt of the documentation, it will be reviewed for approval. If the documentation is found to be insufficient, you will be required to take BI training. Your application will be forwarded on to an HCBS Regional Specialist who will coordinate the required BI training. The specialist will be in contact with you to inform you of upcoming BI training in your area. You cannot become a BI waiver provider without attending the required training or having the training waived through your experience and training.</p> <p>A list of available training times and locations can be found on the HCBS website at:  <a href="http://www.ime.state.ia.us/HCBS/help_ownhome.html">http://www.ime.state.ia.us/HCBS/help_ownhome.html</a></p>									
<p><b>Read and sign the following statement:</b></p> <p>As a Medicaid provider of consumer-directed attendant care services:</p> <ul style="list-style-type: none"> <li>◆ I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.</li> <li>◆ I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.</li> <li>◆ I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.</li> <li>◆ I understand that I must describe in detail my training and/or experience on form 470-3372, <i>HCBS Consumer-Directed Attendant Care Agreement</i>, and this will be reviewed and approved by the Medicaid case manager (not AAA case manager) or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.</li> <li>◆ I have made a copy of this application for my own records.</li> <li>◆ I hereby confirm that all information provided by me on this form is true and correct to my best knowledge.</li> </ul>									
<b>18. Signature</b>									
<b>19. Date</b>			/			/			

**NOTE: Once the application process has been completed, you will receive notification from the Iowa Medicaid Enterprise.**

### III. AGENCIES AND BUSINESSES APPLYING FOR WAIVER SERVICES

<b>16. Tax ID Number</b>			—						
<b>17. Contact Person</b> <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.									
<b>18. Do you have any HCBS waiver-related provider numbers in addition to the one shown in question 1?</b> If “yes,” please, list them here. <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>									
<b>19. Has there been any disciplinary action against you by any licensing boards or certification body?</b> <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>									
<b>20. Have you ever been excluded from participation in the Medicare Program? If “yes,” please explain on a separate piece of paper.</b> <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>									
<b>21. Type of Practice Code (Check One)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> 01 – Individual Applicant</div> <div style="width: 33%;"><input type="checkbox"/> 05 – Government Owned</div> <div style="width: 33%;"><input type="checkbox"/> 09 – Group</div> <div style="width: 33%;"><input type="checkbox"/> 02 – Partnership</div> <div style="width: 33%;"><input type="checkbox"/> 06 – Not for Profit</div> <div style="width: 33%;"><input type="checkbox"/> 10 – University Affiliated Clinic</div> <div style="width: 33%;"><input type="checkbox"/> 03 – Corporation/Profit Organization</div> <div style="width: 33%;"><input type="checkbox"/> 07 – Private Owner</div> <div style="width: 33%;"><input type="checkbox"/> 04 – Hospital Based</div> <div style="width: 33%;"><input type="checkbox"/> 08 – HMO</div> </div>									
<b>22. Type of Ownership Code (Check One)</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> 01 – Individual Applicant</div> <div style="width: 33%;"><input type="checkbox"/> 04 – Partner</div> <div style="width: 33%;"><input type="checkbox"/> 07 – Nonprofit Organization</div> <div style="width: 33%;"><input type="checkbox"/> 02 – Board Member/Commissioner</div> <div style="width: 33%;"><input type="checkbox"/> 05 – Corporation</div> <div style="width: 33%;"><input type="checkbox"/> 08 – Trust</div> <div style="width: 33%;"><input type="checkbox"/> 03 – Sole Ownership</div> <div style="width: 33%;"><input type="checkbox"/> 06 – Government Entity</div> </div>									

**Remittance Statement Control** – Please read instructions on first page before completing!

<b>23. Claims in Process Information (Check one)</b> <input type="checkbox"/> Y = Print suspended claims only once <input type="checkbox"/> A = Print all suspended claims (until paid or denied) <input type="checkbox"/> N = Do not print suspended claims	<b>24. Remittance Sequence (Check one)</b> <input type="checkbox"/> 1 = By member name <input type="checkbox"/> 2 = By member ID
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**25. Indicate the service(s) for which you are applying and attach proof that the requirement is met.**

Service and Requirements	Circle the waiver(s) for which you are applying
<b><input type="checkbox"/> 01 – Adult Day Care (ADC)</b>	
<input type="checkbox"/> 70 – Certificate for Adult Day Care services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate) **Requires submission of a complete Provider Quality Management Self-Assessment	→ IH AH E ID BI
<b><input type="checkbox"/> 02 – Assistive Devices (AD)</b>	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required)	→ E
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→ E
<input type="checkbox"/> 60 – Provider that were enrolled as assistive device providers as of June 30, 2010 based on a contract or letter of approval from an area agency on aging (attach a copy of the letter)	→ E
<input type="checkbox"/> 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→ E

Service and Requirements	Circle the waiver(s) for which you are applying
<b><input type="checkbox"/> 25 – Behavioral Programming (BP)</b>	
<input type="checkbox"/> 46 – You will be contacted in regards to submitting policies, procedures, and forms →	BI MFP
<input type="checkbox"/> 17 –Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441 - 24, Divisions I and III. →	BI MFP
<input type="checkbox"/> 18 –Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481 - 53 or which are certified to meet the standards under the Medicare program for hospice programs →	BI MFP
<input type="checkbox"/> 19 –Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441-24, Divisions I and IV →	BI MFP
<input type="checkbox"/> 08 –Home Health Agency (enter your Medicare Provider # _____) →	BI MFP
<input type="checkbox"/> 20 –Brain injury waiver providers certified pursuant to rule 441-77.39(249A) →	BI MFP
<input type="checkbox"/> 93 – Provider certified under HCBS BI Behavior Programming (no supporting documentation required) →	MFP
<input type="checkbox"/> 94 – A licensed psychologist or psychiatrist (attach a copy of the license) →	MFP
<input type="checkbox"/> 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification) →	MFP
<input type="checkbox"/> 96 – A licensed mental health counselor (attach a copy of the license) →	MFP
<input type="checkbox"/> 97 – A licensed social worker (attach a copy of the license) →	MFP
<input type="checkbox"/> 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification) →	MFP
**Requires submission of a completed Provider Quality Management Self-Assessment	
<b><input type="checkbox"/> 26 – Case Management (CM)</b>	
<input type="checkbox"/> 47 – Meets 441 IAC-24 Case Management (enter your case management # _____) →	E BI
<input type="checkbox"/> 86 – An agency or individual that is accredited through the Commission on Accreditation of Rehabilitation Facilities for case management services (attach current certification and most recent CARF survey report) →	E
<input type="checkbox"/> 87 – An agency or individual that is accredited through the Council on Quality and Leadership (attach current certification and most recent survey report) →	E
<input type="checkbox"/> 88 – An agency or individual that is accredited through Joint Commission on Accreditation of Health Care Organizations (attach current certification and most recent survey report) →	E
<input type="checkbox"/> 89 – An agency or individual that meets Iowa Administrative Code 321 Chapter 21 for case management services and is approved by the Department of Elder Affairs (must submit a letter from Dept. of Elder Affairs that the requirements are met) →	E
<input type="checkbox"/> 90 – An agency or individual that meets Iowa Administrative Department of Public Health in the counties that provide case management according to IAC 641-80.2(135) and 641-80.9(135) (must submit a letter from Dept. of Public Health that the requirements are met) →	E
<b><input type="checkbox"/> 03 – Chore</b>	
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage) →	E
<input type="checkbox"/> 63– Provider that were enrolled as chore providers as of June 30, 2010 based on a contract with or letter of approval from an area agency on aging (attach a copy of the letter) →	E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	E
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____) →	E
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # _____) →	E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →	E

<input type="checkbox"/> <b>04 – Consumer Directed Attendant Care (CDAC)</b>		
<input type="checkbox"/> <b>31 – Assisted Living Provider</b>		
<input type="checkbox"/> 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (attach a copy of the certificate)	→	E
<input type="checkbox"/> <b>29 – Agency</b>		
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # _____)	→	IH AH E ID BI PD
<input type="checkbox"/> 12 – Home Care Agency with written certification from Department of Public Health stating that home care standards and requirements set forth in Department of Public Health rules 641 IAC 80.5(135)-80.7(135) are met (attach a copy of the certificate)	→	IH AH E ID BI PD
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH AH E ID BI PD
<input type="checkbox"/> 13 – Chore provider contracting with an Area Agency on Aging (attach a copy of the contract)	→	IH AH E ID BI PD
<input type="checkbox"/> 14 – Chore provider with letter of approval from an Area Agency on Aging stating that the organization is qualified to provide chore (attach a copy of the letter)	→	IH AH E ID BI PD
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	IH AH E ID BI PD
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	IH AH E ID BI PD
<input type="checkbox"/> 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69	→	IH AH ID BI PD
<input type="checkbox"/> 83 – Provider with a certificate for Adult Day Care services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	IH AH E ID BI PD
**Requires submission of a completed Provider Quality Management Self-Assessment		
<input type="checkbox"/> <b>05 – Counseling (Couns)</b>		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	IH AH
<input type="checkbox"/> 23 – Hospice (attach a copy of the license or enter your Certificate of License or Medicare Provider # _____)	→	IH AH
<input type="checkbox"/> 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	IH AH
<input type="checkbox"/> <b>101 – Crisis Intervention</b>		
<input type="checkbox"/> 102 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # _____)	→	MFP
<input type="checkbox"/> 103 – ICF/ID (enter your Medicaid Provider # _____)	→	MFP
<input type="checkbox"/> 104 – An agency with a contract to provide crisis intervention services with the Department of Human Services (provide documentation)	→	MFP
<input type="checkbox"/> <b>70 – Day Habilitation (DH)</b>		
<input type="checkbox"/> 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→	ID
<input type="checkbox"/> 74 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities for similar services* (attach current CARF certification and most recent CARF survey report)	→	ID
<input type="checkbox"/> 75 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities, but not for similar services*, until next regularly scheduled accreditation at which time the applicant will present documentation to the department that the similar service* requirement is met. HCBS waiver approval will be granted through the expiration date of the current CARF certification (attach current CARF certification and most recent CARF survey report)	→	ID
<input type="checkbox"/> 76 – Previous application for CARF accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of CARF application (Submit a copy of the CARF application. You will be contacted in regards to submitting policies and procedures applicable to day habilitation.)	→	ID
<input type="checkbox"/> 77 – Previous application for Council on Quality and Leadership accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of Council application (Submit a copy of the Council application.)	→	ID
* - Similar services include Personal and Social services, Community Integration services, Community Based Rehabilitation, and Adult Day Care		

<b><input type="checkbox"/> 71 – Environmental Modifications, Adaptive Devices and Therapeutic Resources</b>		
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	CMH
<input type="checkbox"/> 30 – A provider enrolled under the HCBS children's mental health waiver as a Family and Community Support Services provider	→	CMH
<input type="checkbox"/> 45 – Provider previously enrolled as a waiver Home/Vehicle Modifications provider (no supporting documentation required)	→	CMH
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	CMH
<input type="checkbox"/> 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # _____)	→	CMH
<b><input type="checkbox"/> 72 – Family and Community Supports (FCSS)</b>		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	CMH
<input type="checkbox"/> 41– Mental Health professionals licensed pursuant to 645-Chapter 31, 240, or 280 or possessing an equivalent license in another state.	→	CMH
**Requires submission of a completed Provider Quality Management Self-Assessment		
<b><input type="checkbox"/> 34 – Family Counseling (FC)</b>		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	BI
<input type="checkbox"/> 23 – Hospice (attach a copy of the license or enter your Certificate of License or Medicare Provider# _____)	→	BI
<input type="checkbox"/> 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	BI
<input type="checkbox"/> 48 – Individuals who meet the definition of qualified brain injury professionals as designated in 441 IAC 83.81(249A)	→	BI
<input type="checkbox"/> 33 – Agencies certified as brain injury waiver providers pursuant to rule 441-77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441-83.81(294A)	→	BI
**Requires submission of a completed Provider Quality Management Self-Assessment		
<b><input type="checkbox"/> Financial Management Services</b>		
<input type="checkbox"/> 91 – A credit union that is a cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa Department of Commerce (Attach documentation from NCUA or IDC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee	→	IH AH E ID BI PD
<input type="checkbox"/> 92 – A financial institution chartered by the office of the Comptroller of the Currency, a Bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.	→	IH AH E ID BI PD
<b><input type="checkbox"/> 07 – Home Delivered Meals (HDM)</b>		
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	IH AH E
<input type="checkbox"/> 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract)	→	IH AH E
<input type="checkbox"/> 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service (attach a copy of the letter)	→	IH AH E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	IH AH E
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract and enter your Medicare Provider # _____)	→	IH AH E
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH AH E
<input type="checkbox"/> 26 – Hospital (enter your Medicare Provider # _____)	→	IH AH E
<input type="checkbox"/> 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→	IH AH E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	IH AH E
<input type="checkbox"/> 27 – Restaurant licensed and inspected under Iowa Code chapter 135F (attach a copy of the license)	→	IH AH E



<input type="checkbox"/> <b>08 – Home Health Aide (HHA)</b>			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)			
<input type="checkbox"/> <b>09 – Homemaker (HM)</b>			
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # _____)	→	IH AH E	
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH AH E	
<input type="checkbox"/> <b>10 – Home/Vehicle Modifications (HVM)</b>			
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	IH E	
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	IH E	
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→		ID
<input type="checkbox"/> 45 – Provider enrolled as a waiver Home/Vehicle Modifications provider under another waiver (no supporting documentation required)	→	IH E ID BI PD	
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	IH E ID BI PD	
<input type="checkbox"/> <b>73 – In-Home Family Therapy (IHFT)</b>			
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→		CMH
<input type="checkbox"/> 41 – Mental Health professionals licensed pursuant to 645-Chapter 31, 240, or 280 or possessing an equivalent license in another state.	→		CMH
**Requires submission of a completed Provider Quality Management Self-Assessment			
<input type="checkbox"/> <b>21 – Interim Medical Monitoring &amp; Treatment (IMMT)</b>			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH ID BI	
<input type="checkbox"/> 80 – Child care center registered pursuant to 441-109 (attach a copy of the license)	→	IH ID BI	
<input type="checkbox"/> 81 – Preschool registered pursuant to 441-109 (attach a copy of the license)	→	IH ID BI	
<input type="checkbox"/> 82 – Child development home registered pursuant to 441-109 (attach a copy of the license)	→	IH ID BI	
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	IH ID BI	
**Requires submission of a completed Provider Quality Management Self-Assessment			
<input type="checkbox"/> <b>11 – Mental Health Outreach (MHO)</b>			
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate of accreditation)	→	E	MFP
<input type="checkbox"/> 100 – Provider certified under HCBS Elderly Mental Health Outreach (no supporting documentation required)	→		MFP
<input type="checkbox"/> 93 – Provider certified under HCBS BI Behavior Programming (no supporting documentation required)	→		MFP
<input type="checkbox"/> 94 – A licensed psychologist or psychiatrist (attach a copy of the license)	→		MFP
<input type="checkbox"/> 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification)	→		MFP
<input type="checkbox"/> 96 – A licensed mental health counselor (attach a copy of the license)	→		MFP
<input type="checkbox"/> 97 – A licensed social worker (attach a copy of the license)	→		MFP
<input type="checkbox"/> 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification)	→		MFP
<input type="checkbox"/> <b>105 – Nurse Delegation</b>			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→		MFP
<input type="checkbox"/> 106 – A nurse licensed by the Iowa Nursing Board as a registered or license practical nurse pursuant to IAC 655 (attach a copy of the license)	→		MFP
<input type="checkbox"/> <b>12 – Nursing (N)</b>			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH AH E ID	

<input type="checkbox"/> <b>13 – Nutritional Counseling (NC)</b>						
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	IH	E			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH	E			
<input type="checkbox"/> 26 – Hospital (enter your Medicare Provider # _____)	→	IH	E			
<input type="checkbox"/> 28 – Licensed dietitian approved by an Area Agency on Aging (attach a copy of the license and the letter from an Area Agency on Aging)	→	IH	E			
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	IH	E			
<input type="checkbox"/> <b>06 – Personal Emergency Response (PERS)</b>						
<input type="checkbox"/> 25 – Send information pamphlet	→	IH	E	ID	BI	PD
<input type="checkbox"/> <b>41 – Prevocational Services (Prevoc)</b>						
<input type="checkbox"/> 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers (attach current certificate and most recent survey report)	→				BI	
<input type="checkbox"/> 69 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities under standards for work adjustment service providers or organizational employment service providers (attach current certificate and most recent survey report)	→			ID		
<input type="checkbox"/> 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→			ID		
*Providers accredited as an organizational employment service provider will need an approved exception to policy **Requires submission of a completed Provider Quality Management Self-Assessment						
<input type="checkbox"/> <b>20 – Respite</b>						
<input type="checkbox"/> 46 – You will be contacted in regards to submitting policies, procedures, and forms	→			ID	BI	CMH
<input type="checkbox"/> 29 – Provider certified under HCBS ID Respite (no supporting documentation required)	→	IH	AH	E	BI	CMH
<input type="checkbox"/> 79 – Provider certified under HCBS BI Respite (no supporting documentation required)	→	IH	AH			CMH
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	IH	AH	E	ID	BI
<input type="checkbox"/> 09 – Home Care Agency with Iowa Department of Public Health contract (attach a copy of the contract or enter your Contract # _____)	→	IH	AH	E	ID	BI
<input type="checkbox"/> 26 – Hospital (enter your Medicare Provider # _____)	→	IH	AH	E	ID	BI
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	IH	AH	E	ID	BI
<input type="checkbox"/> 35 – ICF/ID (enter your Medicaid Provider # _____)	→	IH	AH		ID	BI
<input type="checkbox"/> 44 – Licensed group living foster care facility (attach a copy of the license)	→	IH	AH		ID	BI
<input type="checkbox"/> 32 – Camp accredited by the American Camping Association (attach a copy of the certificate)	→	IH	AH	E	ID	BI
<input type="checkbox"/> 30 – Provider with a certificate for Adult Day Care services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	IH	AH	E	ID	BI
<input type="checkbox"/> 50 – Residential care facility for persons with mental retardation licensed by DIA (attach a copy of the license)	→	IH			ID	BI
<input type="checkbox"/> 80 – Child care center registered pursuant to 441-109 (attach a copy of the license)	→	IH	AH		ID	BI
<input type="checkbox"/> 81 – Preschool registered pursuant to 441-109 (attach a copy of the license)	→	IH	AH		ID	BI
<input type="checkbox"/> 82 – Child development home registered pursuant to 441-Chapter 110 (attach a copy of the license)	→	IH	AH		ID	BI
<input type="checkbox"/> 78 – Assisted Living Program certified by the Department of Inspections and Appeals as designated in IAC 481-69	→	IH	AH	E	ID	BI
**Requires submission of a completed Provider Quality Management Self-Assessment						
<input type="checkbox"/> <b>17 – Senior Companion (SC)</b>						
<input type="checkbox"/> 37 – Designation by Corporation for National and Community Service (attach documentation substantiating the designation)	→		E			

<b><input type="checkbox"/> 19 – Specialized Medical Equipment (SME)</b>		
<input type="checkbox"/> 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→	BI PD
<input type="checkbox"/> 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # _____)	→	BI PD
<b><input type="checkbox"/> 52 – Supported Community Living (SCL)</b>		
<input type="checkbox"/> 46 – You will be contacted in regards to submitting policies, procedures, and forms	→	ID BI
<input type="checkbox"/> 53 – Provider enrolled under HCBS ID SCL (no supporting documentation required)	→	BI
<input type="checkbox"/> 54 – Provider enrolled under HCBS BI SCL (no supporting documentation required)	→	ID
**Requires submission of a completed Provider Quality Management Self-Assessment		
<b><input type="checkbox"/> 55 – Supported Community Living – 5 Persons (SCL-5)</b>		
<input type="checkbox"/> 51 – RCF/ID (submit plan to come into compliance with IAC 441 77.37(14)"d"(1) and a copy of 5 bed RCF/PID licensure)	→	ID
**Requires submission of a completed Provider Quality Management Self-Assessment		
<b><input type="checkbox"/> 58 – Supported Community Living – 8 Persons (SCL-8)</b>		
<input type="checkbox"/> 52 – ICF/ID (submit plan to come into compliance with IAC 441 77.37(14)"d"(1) and a copy of 8 bed ICF/ID licensure)	→	ID
**Requires submission of a completed Provider Quality Management Self-Assessment		
<b><input type="checkbox"/> 61 – Residential-Based Supported Community Living (RBSCCL)</b>		
<input type="checkbox"/> 65 – Group Living Foster Care Facility (submit copy of group living foster care licensure under IAC 441-114 and a plan to come into compliance with IAC 441 77.37(23)"e"(3))	→	ID
<input type="checkbox"/> 66 – Residential Facility for Mentally Retarded Children (submit copy of Residential Facility for Mentally Retarded Children under IAC 441-116 licensure and a plan to come into compliance with IAC 441 77.37(23)"e"(3))	→	ID
**Requires submission of a completed Provider Quality Management Self-Assessment		
<b><input type="checkbox"/> 62 – Supported Employment (SE)</b>		
<input type="checkbox"/> 55 – Provider certified under HCBS ID Supported Employment (no supporting documentation required)	→	BI
<input type="checkbox"/> 56 – Provider certified under HCBS BI Supported Employment (no supporting documentation required)	→	ID
<input type="checkbox"/> 31 – An agency that is accredited by the commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 34 – An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 36 – An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 42 – An agency that is accredited by the council on Quality and Leadership in Supports for People with Disabilities for similar services (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 43 – An agency that is accredited by the International Center for Clubhouse Development (attach copy of the certificate of accreditation)	→	ID BI
**Requires submission of a completed Provider Quality Management Self-Assessment		

<input type="checkbox"/> <b>18 – Transportation (Trans)</b>	
<input type="checkbox"/> <b>67 – Regional Transit Authority</b>	
<input type="checkbox"/> 38 – Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required) →	E ID BI PD
<input type="checkbox"/> 57 – Transit Agency with a contract with a Regional Transit Agency ( submit copy of the contract) →	E ID BI PD
<input type="checkbox"/> <b>68 – Area Agency on Aging</b>	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 17-4.4(231) (no supporting documentation required) →	E ID BI PD
<input type="checkbox"/> 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract) →	E ID BI PD
<input type="checkbox"/> 62 – Letter from Area Agency on Aging stating the organization is qualified to provide the service (attach a copy of the letter) →	E ID BI PD
<input type="checkbox"/> <b>69 – Mile</b>	
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required) →	E ID BI PD
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required) →	E ID BI PD
<input type="checkbox"/> 71 – Accredited HCBS provider (no supporting documentation required) →	ID
<input type="checkbox"/> 72 – Contract with county government (attach a copy of the contract) →	ID

<b>26. Signature of Authorized Official</b>									
<b>27. Date</b>			/			/			

**Note: Once the application process has been completed, you will receive notification from the Iowa Medicaid Enterprise.**